

ORGANISATION AND MANAGEMENT OF HEALTH CARE IN PRISON



Jörg Pont
Timothy Wilfrid Harding

Guidelines

COUNCIL OF EUROPE



CONSEIL DE L'EUROPE

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List of Abbreviations

CME	Continuing Medical Education
CPT	European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment
EComHR	European Commission of Human Rights
ECHR	European Convention of Human Rights
ECtHR	European Court of Human Rights
EMR	Electronic medical records
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICRC	International Committee of the Red Cross
PHC	Primary Health Care
SOP	Standard Operating Procedure
SWOT	Strengths, weaknesses, opportunities, threats
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WMA	World Medical Association

Introduction

Historical backdrop

For many years public health authorities at both national and international levels paid little or no attention to health care in prisons. World Health Organisation (WHO) in the first four decades of its existence carried out no substantive work and published no documents about health services in prisons or the health of prisoners. Prison health was little studied, did not feature in academic programmes and was rarely the subject of published articles in medical journals. Prisons were a “world apart” and the few doctors working in prisons were employed and supervised by the prison administration and had no contact with local or national health bodies, medical schools or other professional bodies.

Providing hospital care for prisoners was difficult and prisoners in hospital were subjected to humiliating security measures, such as handcuffing to beds and the presence of security staff during intimate consultations and examinations. There were no standards concerning the levels of health staff; prison guards screened requests for medical consultations, were fully aware of prisoners’ diagnoses and treatment; indeed they were often tasked with distributing medications and even giving injections.

Given this history, it is not surprising that it has proved difficult and slow to implement changes to bring prison health care into line with health care in the community, to provide the necessary links between health services within prisons and health structures outside, which are nevertheless vital for ensuring comprehensive coverage of the health needs of prisoners. The health needs of prisoners have evolved with growing numbers of prisoners presenting chronic disorders related to their age and life style (hypertension, diabetes and heart conditions), a significant proportion of the prison population suffering from mental disorders, and infectious diseases related to poverty and to injection of substances of abuse.

Providing hospital care, sometimes as an emergency, in humane conditions with access to the whole range of diagnostic and therapeutic measures has proved a particularly difficult challenge. In few states can emergency psychiatric care under conditions equivalent to that available for non-prisoners be provided.

Preventive care was equally deficient, with few prophylactic measures such as vaccinations and prison conditions often highly harmful to health: overcrowding, poor ventilation, out-dated sanitation (the use of slopping out buckets for urine and defecation in cells was widespread) and poor nutrition.

It was during the 1980s that these problems received attention by the health authorities for the first time as a direct result of the AIDS pandemic. By 1985, it became apparent that the prevalence of Human Immunodeficiency Virus (HIV) infection was much higher in the prison population than in the community, due to the tendency of substance abusers to be incarcerated. This was confirmed by a number of epidemiological studies, notably a study commissioned by the Council of Europe and published in the *Lancet* in 1987.¹ WHO for the first time became aware of conditions in prisons and the WHO Special Programme on AIDS carried out a study and published directives aimed at preventing and treating HIV infections in prison also in 1987. Particular attention was paid to the risk of HIV transmission by penetrative sex or by sharing of material for injection. Although the WHO recommendations concerned specifically HIV/AIDS, they had a much wider impact: public health authorities were made aware of the importance of an inclusive approach fully involving the prison environment and the principles of equivalence of care and preventive measures were spelt out for the first time. If prisoners with HIV infection had the right to the same treatments and the same protections (confidentiality, non-segregation and non-discrimination) as patients in the community, the same should apply to the whole range of medical conditions.

The other stimulus to change which came in the 1980s was the work of the European Commission of Human Rights (EComHR) at that time “the Commission”, which no longer exists, carried out a first examination of complaints made by individuals under the European Convention of Human Rights (ECHR) establishing the principle which was later to be confirmed and elaborated by the European Court of Human Rights (ECtHR), that failure to provide adequate health care and environment to prisoners suffering from serious medical conditions could constitute a violation of Article 3 of the ECHR (prohibition of torture). This lead was followed by the European Committee

1. Harding TW. Aids in prison. *The Lancet* 330, i8570, 1260-1263, 1987

for Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which began its substantive work visiting places of detention in 1991, and rapidly identified failings in the health care of prisoners as a major concern under its mandate. In 1993 the CPT devoted one of its first substantive sections of its annual reports to standards of prison health care (detailed below). This was to become a template to be built on in elaborating recommendations of the Committee of Ministers of the Council of Europe. It was also instrumental in alerting WHO to develop activities concerning prison health, which has been largely enhanced by the WHO Regional Office in Copenhagen.

The many encouraging developments over the last twenty years should be seen against this historical backdrop. The history also explains resistances and doubts within both prison and health administrations to develop meaningful links, lines of communication and mechanisms to solve conflicts which are often crystallised around budgetary responsibilities and security issues related to health care of prisoners.

Organisation of health care in prison

Basic principles regarding organisation of health care in prison were elaborated and integrated, already 20 years ago, in the Recommendation of the Committee of Ministers of the Council of Europe Rec (98)7 concerning the Ethical and Organisational Aspects of Health Care in Prison.² The member States are recommended to take these principles into account while reviewing their legislation and practice in the area of health care provision in prison. The Recommendation highlights that the medical practice in the community and in the prison context should be guided by the same ethical principles and that the respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community. The recommendation also refers to the reforms in structure, organisation and regulation of prison health care services that had taken place in several member States, including the different administrative structures at federal and state levels.” The Committee of Ministers Recommendation (98)7 remains a cornerstone document in this area.

The fundamental rights of the imprisoned persons and the ethical principles regarding provision of prison health care have essentially remained the same. Meanwhile, their practical application, over the last twenty years, has been elaborated in various international documents and the process of reforms in structure, organisation and governance of prison health care services in several Council of Europe member States has progressed considerably. The main driving force for organisational changes has been the increasing conviction that health care in prison needs to be closely aligned to and integrated with health care in the community. The structural and organisational changes in such countries have created a range of different models, offering other countries the possibility to identify and choose the most appropriate one.

2. Recommendation No. R (98) 7 <https://rm.coe.int/09000016804fb13c>

This publication aims at providing guidance to policy makers and officials of relevant institutions to ensure that the health policy in prisons is integrated into, and compatible with national health policy. The Council of Europe publication “Prison Health Care and Medical Ethics”- a manual for health care workers and other prison staff with responsibility for prisoners’ well-being, can be referred to as a complementary guide with practical information regarding provision of health care in prison.³

3. Prison Health Care and Medical Ethics. A manual for health-care workers and other prison staff with responsibility for prisoners’ well-being. Council of Europe, November 2014 <https://rm.coe.int/publications-healthcare-manual-web-a5-e/16806ab9b5>

International standards as a fundamental basis for the provision of health care to imprisoned persons

The right to health care

The United Nations' principles highlight that "it is the fundamental right of everyone to the enjoyment of the highest attainable standard of physical and mental health";⁴ that "states are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services" and that "all health facilities, goods and services must be respectful of medical ethics..."⁵

The right of the imprisoned persons to health care is one of the basic principles of the Recommendation of the Committee of Ministers of the Council of Europe Rec(2006)2 on the European Prison Rules that "persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody."⁶

The ECHR does not explicitly stipulate the right to health care, but States denying the detained or imprisoned persons appropriate health care have

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4. United Nations: International Covenant on Economic, Social and Cultural Rights Art.12 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>
 5. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html>
 6. European Prison Rules 2006, Council of Europe Rule 2. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d8d25

repeatedly been condemned by the ECtHR for violation of Article 2 (right to life) or Article 3 “(prohibition of torture) of the ECHR”.⁷ In this regard the Thematic Report- Health-related issues in the case-law of the European Court of Human Rights,⁸ will be referred to, in the relevant chapters below.

The case law of the ECtHR clearly establishes that under Article 3 the State must ensure that, “given the practical demands of imprisonment, (a prisoner’s) health and well-being are adequately secured by, amongst other things, providing him with the required medical assistance” *Kudla v. Poland*, (judgement of 26 October 2000). Three principles emerge: adequacy, suffering caused, and the fact that there are contributing factors beyond medical assistance alone, presumably the physical and emotional environment of the prison establishment.

It is worth examining some individual decisions to understand what situations are deemed by the instances established under the ECHR as problematic under Article 3.

Two of the cases examined by the EComHR show the early emergence of issues. Under *Bonnechaux v. Switzerland* (decision of 5 December 1978), the Swiss authorities were required to establish that an elderly prisoner suffering from diabetes had access to adequate medical care *within* the prison. The Commission went further in a later case (*De Varga Hirsch v. France*, (decision of 9 May 1983), also concerning an elderly remand prisoner suffering from diabetes, coronary insufficiency and arteriopathy of the lower limbs, the Commission examined not only the medical care within the prison but also the possibility of hospitalisation in a public hospital outside the prison system. In both cases the EComHR considered that the assurances provided by the authorities were convincing and the issues were not referred to the ECtHR. However, more than 35 years ago the relevance of the ECHR to health care in prisons had been established and encompassed not only the work of the prison medical service, but access to the public hospitals.

Since then the ECtHR has examined many hundreds of complaints concerning health care of prisoners and in a significant number has found violations of Article 3 (prohibition of torture) and in a few cases violations of Article 2 (right to life) of the ECHR when a prisoner’s death was attributed to inadequacies of medical treatment. Furthermore, in a number of cases the ECtHR

7. European Convention on Human Rights, Council of Europe https://www.echr.coe.int/Documents/Convention_ENG.pdf

8. European Court of Human Rights, Thematic Report - Health-related issues in the case-law of the European Court of Human Rights, 2015. http://www.echr.coe.int/Documents/Research_report_health.pdf

has requested the State party to provide adequate medical care during proceedings before the ECtHR under Rule 39 (interim measures), thus underlining the grave consequences of inadequate care and the slowness of the State authorities' responses.

In one case (*Affaire Poghossian c. Géorgie*) the ECtHR considered that in view of the fact that almost forty applications concerning lack of care submitted to the ECtHR, there was a systemic problem concerning the administration of adequate medical care to prisoners infected, inter alia, with hepatitis C.

Clearly, the deficiencies which were considered as violations under the ECHR are not isolated cases and are indicators of widespread failings in health care, which continue until the present. The recommendations coming from the Council of Europe, the WHO, the International Committee of the Red Cross (ICRC) and others have therefore had only a limited effect. It behoves the authorities concerned, both in the health and prison sectors, to take note of the regularity of Article 3 violations concerning inadequate health care for prisoners in many countries.

What problems do the cases considered by the ECtHR, often confirmed by published visit reports of the CPT, reveal?

- ▶ Deficiencies at primary care level *within* the prison are frequently found: delays in gaining access to a doctor or nurse (the CPT has often detailed severe shortages of medical and nursing staff); lack of diagnostic tools which should normally be available at primary care level (electrocardiogramme, simple laboratory tests); lack of regular follow up for prisoners with chronic conditions such as hypertension, heart disease, hypertension, hepatitis B or C, or even tuberculosis; limited range of medications available, especially antibiotics, antiviral medications for treating HIV infection or hepatitis C. The lack of individual medical files is highlighted as a widespread problem. The CPT has frequently criticised the fact that medical consultations in prisons are recorded with a few words in a register without an individual medical file, the difficulties of referring prisoners for a specialist assessment or for examinations which cannot be carried out within the prison.
- ▶ The unavailability of dental care in prisons. Again the CPT has frequently described the excessively long waiting periods to see a dentist and the fact that the only treatment available free of charge is tooth extraction.
- ▶ Many Article 3 violations found by the ECtHR concern delays and difficulties in access to secondary level care. In one case a prisoner with chronic hepatitis and serious kidney disease leading to chronic renal failure had not had any specialist assessment or treatment for almost

- four years (*Holomiov v. Republic of Moldova*); in another case a prisoner suffering from duodenal ulcer, diabetes and cardiac disease, in need of regular specialist medical care, was left without specialist care for a prolonged period (*Ashot Harutyunyan v. Armenia*); shortcomings in the management of patients with several concomitant illnesses, such as delays in hospitalisation and failures to carry out necessary investigations, for example *Helicobacter pylori* test in a patient with peptic ulcer, treated inappropriately for spinal injuries with medications which could induce gastrointestinal bleeding (*Kolesnikovich v. Russia*).
- ▶ Several cases concern long delays in carrying out surgery leading to prolonged and unnecessary suffering; for example a patient with multiple kidney stones leading to frequent episodes of severe pain denied surgery for more than four years (*Pilcic v. Croatia*); a scheduled operation carried out with a delay of one year (*Affaire Kotsaftis c. Grèce*).
 - ▶ Patients with terminal illnesses denied the possibility to die in dignity outside the prison; for example a man with metastatic prostate cancer (*Affaire Dorneanu c. Roumanie*) where the authorities were said to have prioritised formalities over humanitarian considerations.
 - ▶ Failures in the management of prisoners with infectious diseases: unnecessary segregation of a prisoner with HIV infection (*Martzaklis and others v. Greece*); delays in treatment (*Aleksanyan v. Russia*).
 - ▶ Physical restraints applied during examinations and treatment carried out in hospital or during hospitalisation (*Mouisel v. France; Tarariyeva v. Russia*).
 - ▶ The ECtHR has found on a number of occasions that the failures in management of prisoners with mental disorders caused unnecessary suffering or even death by suicide. Some problems relate to lack of treatment by a psychiatrist, no access to necessary medication. However, the leitmotiv of the case-law concerning prisoners suffering from mental disorders is the harmful effect of the “normal” prison environment. Thus, a man serving a very long prison sentence who developed a chronic psychotic condition should not be kept in a normal prison environment (*Affaire Riviere c. France*); two prisoners suffering from acute psychotic symptoms who committed suicide by hanging after a few weeks in prison should have been hospitalised rather than being kept in seclusion (*Keenan v. United Kingdom, Renolde v. France*). More generally the prison environment could lead to unnecessary suffering; such prisoners needing transfer to a protected environment or psychiatric hospital (*Dybeku v. Albania; Slawomir Musial v. Poland*. In one case the ECtHR considered that it was inappropriate to expect other

prisoners to monitor and support a mentally-ill cell-mate (*Kaprykowski v. Poland*), in another case the prison psychiatric wing was said not to provide the level of care and protection needed by a prisoner with a serious mental disorder (*Affaire Claes et autres c. Belgique*), a finding which concurs with CPT observations in a number of countries.

The case-law which has been summarised is a catalogue of failures in the health care of prisoners from many countries. It is certain that these cases represent only the tip of the iceberg and that in many countries the failures are systemic. This is borne out by the findings made during the CPT's country visits where delegations continue to find sub-standard health care of prisoners in many countries. National inspection mechanisms also describe unacceptable levels in the standards of health care.

At this stage it is worth drawing some general conclusions from these findings which will focus on the measures needed to overcome these systemic problems and shortcomings:

1. Primary health care within prisons is often under-resourced and understaffed. Diagnostic materials are insufficient. In many cases, there is no individual medical file. Doctors working in prisons have great difficulties in getting satisfactory responses from hospitals and other specialist services when these are required.
2. Specialist services which could be made available within prisons are either absent or under-resource: dental care, specialist consultations, including psychiatric care.
3. The normal prison environment is harmful and amounts to inhuman and degrading treatment for some prisoners: those with terminal illness, those with serious mental disorders, those with chronic infectious diseases.
4. Hospitalisation of prisoners is problematic. Hospitals do not have the necessary infrastructure to ensure a secure environment, leading to physical restraints being used. There are long delays in undergoing specialist examinations and surgery.

A range of international documents, developed by the United Nations, Council of Europe, WHO and WHO/United Nations Office on Drugs and Crime (UNODC) have established a fundamental basis for organisation and management of prison health care and the ethical conduct of prison health care staff (see Appendix I).

The essence of this document can be summarized as follows: the sole task of health care providers in prisons and detention centres is to provide health care with undivided loyalty to the patients, including preventive health care and recording and reporting signs of violence and ill-treatment, acting as the patient's personal caregiver without becoming involved in any medical actions that are not in the scope of patient's health and well-being; access to health care should be unrestricted; the provision of health care should be equivalent to health care in the community, confidential and respectful of the patient's autonomy, with conducted in unrestricted clinical independence with high professional competence, and should include prevention and humanitarian support; health care for imprisoned and detained persons is a whole state responsibility and should be as closely as possible aligned to, integrated into, and compatible with national health policy.

Legal framework and legal implications

The right to health or “the highest attainable standard of health”⁹ of the imprisoned persons in international human rights law is laid down in covenants and conventions, i.e. legally binding to the signatory states.¹⁰

In the ECHR,¹¹ the right to health of persons deprived of liberty goes under both, the right to life, Article 2, and prohibition of torture, Article 3.

However, none of the international instruments contain a definition of what are the highest attainable standards of physical and mental health in prison and of what constitutes inhumane and/or degrading treatment in the context of health care. This allows for considerable discretion in interpreting standards regarding provision of health care. Therefore, in many international declarations, recommendations, rules, standards and guidelines it is stipulated that health care for the imprisoned persons should have the same quality level as for citizens in the community (Annex 1). This is not legally binding and is also called “soft law”, however, the ECtHR, increasingly refers in

9. Constitution of the World Health Organization www.who.int/governance/eb/who_constitution_en.pdf

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html>

10. The International Covenant on Economic, Social and Cultural Rights, Article 12; UN Convention on the Elimination of All Forms of Discrimination Against Women, Article 12

11. European Convention on Human Rights, Council of Europe https://www.echr.coe.int/Documents/Convention_ENG.pdf

its judgements concerning the provision of health care for imprisoned persons, to these standards.

At national level, in specific laws or penal laws in most of the Council of Europe member States the provisions related to health care for detained or imprisoned persons are in conformity with the international conventions and recommendations. Health care requirements for imprisoned persons should not differ from those of citizens in the community. Particularly free access to health care and preventive health care of highest attainable quality, patient's autonomy, medical confidentiality, medical professional independence and certified medical competence, should be included in the general health laws. In few member States there are separate legal provisions on health care for the community and for the detained and imprisoned persons. In some cases such separate provisions for imprisoned persons do not fully comply with those for citizens in the community.

However, the legal peculiarities of providing health care in prison need also to be taken into consideration, i.e. that, in contrast to providing health care in the community, the relationship between health care providers and the patients in prison is not fully based on a free will. In the free world, an appointment made by a patient with a physician implies basic consent for the physician to make a diagnosis and offer treatment. In the prison setting such an implied consent cannot be assumed because detainees can normally not choose their physician and the admission medical examination is rarely initiated by the patient concerned, but is usually ordered by the prison authorities. Implied consent of an imprisoned or detained person to undergo medical care can be assumed only if it has been made clear to the patient that the physician is obliged to offer the examination on admission. In this situation, building a sustainable patient–doctor relationship requires that the detained patient can rely on the unrestricted clinical independence of the physician.

Medical ethics in prison

One of the many peculiarities of prisons and other detention centres is that two professional groups with completely different tasks work under one and the same roof. The tasks of the prison governors and the custodial staff are detention during the remand period, execution of sentences, safety and security and support for social and criminological rehabilitation in accordance with penal laws. The tasks of the health care professionals are maintenance of health, prevention, detection and treatment of health disorders and the individual health care for imprisoned patients in accordance with

professional rules and health care ethics. For the accomplishment of these different tasks of both categories of professionals, mutual understanding and acceptance of each other's rules, ethics and challenges, while respecting a clear separation of professional roles, is essential. Health care professionals providing care in prisons and detention centres must understand and accept safety and security rules under the prison law and prison governors and custodial staff must understand and accept medical professional rules and medical ethics as specified in the internationally consented documents. In spite of the different governance structures of health care in prison, conflicts and misunderstandings between health care and custodial staff stem primarily from a lack of knowledge and understanding of ethics and acceptance of each other's professional profile.

As these guidelines address primarily non-medical decision makers involved in prison health care management, a summary of ethical standards and its practical implications is also included

Prison health care ethics does in no way differ from the ethics applied in the community health care, i.e. it is based on the worldwide accepted World Medical Association (WMA) International Code of Medical Ethics.¹² However, the ethics in providing health care for detained and imprisoned persons has been further specified in a number of international documents.¹³

12. International Code of Medical Ethics, World Medical Association, <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics>

13. Human Rights Office of the High Commissioner: Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1982, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>;
Council of Europe. CPT standards: Substantive sections of the CPT's General Reports, Extract from the 3rd General Report 1993, <http://hudoc.cpt.coe.int/eng?i=p-standards-inf-1993-12-part-en-1>
United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf
Recommendation No. R (98) 7 <https://rm.coe.int/09000016804fb13c>
European Prison Rules 2006, Council of Europe Rule 2. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d8d25

The sole task of health care professionals is to care for the health and the well-being of the detained and imprisoned persons, including preventive health care and the recording and reporting of signs of violence and ill-treatment. The CPT emphasises that, "A prison doctor acts as a patient's personal doctor. Consequently, in the interest of safeguarding the doctor/patient relationship, he should not be asked to certify that a prisoner is fit to undergo punishment. Nor should he carry out any body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in".¹⁴The non-involvement of medical staff in body searches and in any part of the decision-making process, resulting in solitary confinement as disciplinary punishment, is also stipulated in the respective Statements of the WMA.¹⁵ Medical interventions required by the authorities that are not in the interest of the imprisoned person, such as testing for drug consumption, intimate body searches or forensic examinations need to be performed by medical professionals not involved in the care of the imprisoned persons.

Ethical corner stones in providing prison health care may be summarized under the following headings:¹⁶ a. Access to health care; b. Equivalence of care; c. Patient's consent and confidentiality; d. Preventive health care; e. Humanitarian assistance; f. Professional independence; g. Professional competence.

- a. **Access to health care** includes the obligation of the health care professionals to offer a medical examination on admission without delay (within 24 hours) and access to primary health care provided by a qualified general practitioner or family doctor and her/his assisting nurses and a dentist/stomatologist whenever needed. The application for consultation should be on a confidential basis and without selection barriers by non-medical staff. Information on how to access medical consultation and on the organisation of health care should be provided to every newly admitted person, preferably in written form. Access to secondary health care and hospital care, upon advice of the general practitioner, needs to be guaranteed by employed or contracted specialists, particularly psychiatrists, and by fully-equipped hospitals whenever needed. Appropriate arrangements must be in place for instant medical

14. Council of Europe. CPT standards: Substantive sections of the CPT's General Reports, Extract from the 3rd General Report 1993, <http://hudoc.cpt.coe.int/eng?i=p-standards-inf-1993-12-part-en-1>

15. Statement on body searches of prisoners, World Medical Association, 2017, <https://www.wma.net/policies-post/wma-statement-on-body-searches-of-prisoners>

Statement on solitary confinement, World Medical Association, 2017, <https://www.wma.net/policies-post/wma-statement-on-solitary-confinement>

16. See footnote 14.

care at any time in emergency situations. Unimpaired access to health-care in detention centres and prisons implies that prison managers and administrations need to ensure appropriate health care professionals in prison and good communication and co-operation with health care professionals and hospital facilities outside prisons.

- b. Equivalence of care** stands for the same level of health care quality in prison as in the community. This can only be achieved by close cooperation and integration of prison health care with community health care and public health in relation to legal regulations, licensing procedures, supervision and control of minimum requirements of equipment and qualifications, common staff training and recruitment procedures and inclusion of prisoners in national health programmes. Beyond its importance as an ethical principle, integration and equivalence of prison and community health care are an indispensable need for Public Health as clearly stated in international documents.^{17,18} As integration is an institutional consequence of the principle of equivalence, some professionals have suggested to refer to them as one single principle of equivalence and integration.¹⁹ Given that the percentage and severity of many health disorders among imprisoned persons is much higher than in the community and that it is the state's obligation to care for these persons, researchers have also brought forward the argument that the level of health care in prison being merely equivalent to that in the community might not be sufficient but should be of even higher standards.²⁰
- c. Patient's consent and medical confidentiality** should not only be understood as important ethical principles of health care but also as inevitable professional tools for providing health care: without patients' co-operation and consent little, if any, treatment success can be achieved and without patients' trust in the health care team's professional confidentiality only deficient patients' histories can be obtained.

17. WHO/UNODC: Good governance for prison health in the 21st century. A policy brief on the organization of prison health. https://www.who.int/hiv/pub/prisons/prison_health/en/

18. WHO Moscow Declaration on Prison Health as Part of Public Health. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health>

19. See footnote 17.

20. Lines R. From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. *Int J Prisoner Health* (2006) 2:269-280.

Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole.

Medical confidentiality needs to be observed during medical examinations and consultations which, as a rule, should be conducted in privacy, in the medical consultation room. All medical examinations of prisoners should be conducted out of the hearing and – unless the doctor requests otherwise – out of the sight of prison officers. Confidentiality needs also to be observed in relation to drawing-up and storing medical files, by not disclosing any patient-related medical data without the expressed permission of the patient or upon an official order from the court. The medical information should be confidential, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others.

Any breaches of the principles of patient's consent and medical confidentiality out of the necessity need to be well-grounded and carefully documented by the doctor in the medical file.

- d. In addition to curative and nursing/palliative care, the health care in prison includes also **preventive health care**, such as:
- ▶ supervision of healthy living conditions, including space, cleanliness and hygiene, sanitary conditions, food and water quality control, heating, lighting, ventilation, physical and mental exercise; although in most prison systems and penal codes the head of the prison health care team or chief doctor is entitled to supervise these living conditions, it needs to be acknowledged that for a comprehensive high quality supervision, including regular bacteriological assessments, the support, expertise and technical tools of a fully equipped public health institution and laboratory is indispensable – a further argument for close co-operation/integration with public health authorities in the community;
 - ▶ health promotion for all persons living and working in the prison environment, including mental health promotion, prevention of violence and suicide also need the support of public health institutions as described below in the chapter “Prison: a pathogenic environment and an opportunity for improving health”;
 - ▶ the prevention of the spread of transmissible diseases, such as tuberculosis, drug-resistant tuberculosis and the blood borne virus infections, hepatitis B and C and HIV/AIDS, that are of much higher prevalence in prison than in the community and the preventive activities, diagnosis,

- treatment and epidemiological survey and documentation of such infectious diseases also need the integration with public health institutions and their relevant National Programs.
- e. **Humanitarian assistance** from health care professionals in prison is required for imprisoned persons who are particularly vulnerable in the prison environment due to their gender, age, physical or mental impairment, type of offense, or their belonging to ethnical, religious, political or sexual minorities; health care professionals can identify their vulnerability in confidential medical examinations/consultations and, with their consent, give advice to the prison management for meeting their special needs and their protection, such as appropriate placement in the prison.
- f. *Professional independence of the prison health care staff from the prison authorities is a major challenge for health care in prison. According to the World Medical Association, professional autonomy and clinical independence are the “assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals,” and that “it is a critical component of high quality medical care and an essential principle of health care professionalism.”²¹ Keeping professional clinical independence is particularly demanding in the coercive environment of detention centres and prisons. The risk of interference by prison administrations in clinical independence is bigger if health care is directly subordinated to these administrations, particularly in military-like hierarchies. Health professionals who concurrently work in prison and in the community are more likely to retain their sense of professional independence. The greater the co-operation with and supervision from national health authorities, the lower the risk of inappropriate interference with clinical independence by custodial administrations.²² Improvement of clinical independence of prison health care professionals has been one of the reasons for transferring prison health care from prison administrations to community health administrations. Countries that have transferred the management of prison health care from prison administrations to ministries of health or public health authorities report on increased professional independence of health care professionals.²³*

21. World Medical Association. Declaration of Seoul on Professional Autonomy and Clinical Independence 2008.
<https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinical-independence/>
22. Pont J, Enggist St, Stöver H, Williams B, Greifinger R, Wolff H: Prison healthcare governance: guaranteeing clinical independence. *American Journal of Public Health* (2018) 108(4) 472–476.
23. Hayton P, Gatherer A, Fraser A. Patient or prisoner: does it matter which ministry is responsible for the health of prisoners? A briefing paper for a network meeting, Copenhagen; World Health Organization, Regional Office for Europe, EUR/10/05, October 2010.

- g. The professional competence and clinical skills required for providing quality health care in prison are usually underestimated by both, lay persons and medical colleagues. At primary health care level, in addition to the full competence of a general practitioner or family doctor or nurse, a sound knowledge on medical ethics in prison, on the particularly prevailing health disorders in prison, such as mental health disorders, drug dependency and transmissible diseases and the professional screening, documentation and reporting of violence, are needed.

Health care professionals working in prison must undergo the same certified continuous medical education (CME) as their colleagues working in the community; for providing professional training and CME and also accreditation and licensing for prison health care professionals, close co-operation and integration with public health authorities is indispensable.

Organisational and management structures of prison health care in Council of Europe member States

In the recent years, structural changes have been made to prison health care services in a number of member States. The degree of co-operation with the public health care services differs from one country to another. In some countries, the responsibility for the management of the prison health care has been placed under the Ministry of Health, in some others under a separate department of the Ministry of Justice, whereas in several countries prison administrations remain exclusively responsible for the provision of prison health care. Such different approaches in the Council of Europe member States were also reflected in the replies to a questionnaire that the Council of Europe sent in 2015 to relevant institutions in its member States through the members of the European Committee on Crime Problems (CDPC). Out of 47 member States, 34 of them, representing 49 prison systems (including *Länder* and Cantons) submitted completed questionnaires, therefore the collected information provided only a general overview of the different structural models or undergoing changes and of the shortcomings and challenges faced by the relevant institutions.

The survey showed that **budgeting** patterns related to prison health care varied considerably among member States: either fully provided by the ministry responsible for the prison system (included or separated from the general prison budget) or partly by the ministry responsible for the prison service and partly by the community health care institutions, with a range of 3% to 96.5 %. In one member State the Ministry of Health covered the expenses for health care services provided in state financed programs (such as: oncology, tuberculosis, HIV/AIDS). In another one support was provided by the Global Fund for HIV and tuberculosis services. Prison health care was completely budgeted by the community health institutions in four countries.

The separation of health care budgets from prison budgets at institutional and central administration level is strongly recommended in order to facilitate a better management of the health care needs, separated from other prison-related financial demands.

Mandatory public **health insurance** for the imprisoned persons was established only in some member States. In few others, prisoners benefited either from mandatory health insurance contracted before their imprisonment or were requested to contribute to the costs for health services out of their pocket.

According to international standards,^{24,25} provision of necessary health care services should be free of charge.

The **total amounts per capita** spent for prison health care ranged from 85 € to 9205 €, with a median of 801 €. This extremely wide range needs to be cautiously interpreted as it reflects not only a wide variety of pecuniary wealth of member States but also the structures and the efficiency of administrations.

Management of prison or detention centres in some cases was outsourced to for-profit private companies or the health care services in state-managed prisons were outsourced to for-profit companies.

24. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

25. Commentary to Recommendation R(2006)2 the European Prison Rules of the Committee of Ministers to member States on the European Prison Rules; https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680795966

The **employment** of health care professionals likewise varied considerably: most countries had civil staff, including both, civil servants and privately contracted staff, while in some countries, either all or partly health care staff was integrated within the uniformed prison staff. Full-time and part-time employment of health care staff, paid either by the ministry responsible for the prison service or by community health institutions, had salary scales equal, higher or lower than in the community.

The **collaboration/co-operation** of prison health care management with the community health care services also differed considerably: some countries reported co-operation with the Ministry of Health/Public Health authorities to a certain extent, such as regarding assessment and inspection of hygiene, food, living conditions and medical documentation, licensing/certification of health services in prison and prevention of communicable diseases in prison. Some countries reported on having developed and issued national standards of prison health care and/or Standard Operating Procedures (SOPs) as national guidelines for the management of the existing health care services and for future structural and management processes regarding prison health care.²⁶

In all countries which replied to the questionnaire, **primary health care** was provided in prison and detention institutions, while hospital care was provided either only in civil hospitals or in both, prison hospital services and civil facilities.

Health management documentation, including medical records, was established through electronic software in all prisons of some countries, in some prisons of some other countries and not at all in the rest of them.

A **2017 update** of the earlier collected data²⁷ revealed a slightly increased number of member States in which the prison health care was completely under the responsibility of the Ministry of Health and/or public health authorities while the number of those where the health authorities were partly or regionally responsible for health care in prison or in the process of taking over such responsibility remains the same, and a decrease among those where the governance of health care in prison was completely under the ministry responsible for the prison service, i.e. Ministry of Justice, Ministry of Corrections or Ministry of the Interior.

26. E.g. Standards of Medical Services and Additional Standards of Medical Services for the Persons with Special Needs in Prisons and Detention Facilities in Georgia

27. Council of Europe, Multilateral Meeting on Organisation and Management of Prison Health Care, Strasbourg, 12-13 October 2017. Criminal Law Co-operation Unit, <https://www.coe.int/en/web/criminal-law-coop>

With the intention to ensure more independence for health care staff and health care management from the prison administrations, several member States have established medical departments directly under the responsibility of the relevant ministry or under direct scrutiny of the parliament. Such governance pattern allows for an independent health care budget, separated from other high financial demands in prison.

In a situation with a wide variety of governance structures and management patterns of prison health care in the Council of Europe member States, the arising question is which of them would be the best in terms of quality and efficiency in providing health care services to imprisoned persons. For the time being, there is no precise answer to this question due to lack of systematically collected data on prison health care in most countries and lack of internationally applicable health care performance indicators available that could allow for comparative studies, although at national level such indicators have already been developed.²⁸

During the last three decades worldwide there has been a steadily increasing number of countries that have shifted the responsibility for the management of prison health care to the ministries of health or public health authorities. WHO and UNODC have strongly supported this development, emphasising that “health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions based on the importance of equivalence of care and integration of prison health care into public health and the professional independence of health care providers from prison authorities”.²⁹ Countries that transferred the management of prison health care from prison administrations to ministries of health or public health authorities report on increased professional independence for health care professionals³⁰ and, although yet with a low level of evidence,

28. Kintz, Kimberly E., “Quality measures in correctional health care” (2013). Scholar Archive. 990.

Public Health England, Health and Justice Annual Review 2016/17

29. WHO/UNODC: Good governance for prison health in the 21st century. A policy brief on the organization of prison health. https://www.who.int/hiv/pub/prisons/prison_health/en/

30. Hayton P, Gatherer A, Fraser A. Patient or prisoner: does it matter which ministry is responsible for the health of prisoners? A briefing paper for a network meeting, Copenhagen; World Health Organization, Regional Office for Europe, EUR/10/05, October 2010.

improved quality of health care³¹ as well. However, WHO and UNODC have also made it clear that “transferring prison health care to the jurisdiction of health ministries will be a long process” – in general it took countries more than a decade to complete the process - and that “success and not putting prisoners at increased health risks, require that governments give this process the highest political commitment, communicate fully across all levels of management and personnel, and carefully plan and implement the practical steps, including all necessary budgetary implications and transfers of funding.”³²

Some countries undergoing the transfer process have also reported on difficulties or have indicated possible adverse effects, such as: a potential of disagreements between the penal institutions and the public health entities providing health care services within the prison system; an organisational change of prison health care services that is merely apparent rather than real; insufficient coordination and co-operation between security staff and health care staff; insufficient continuity of care for prisoners if primary health care is provided by health care providers on duty from a regional community health facility; concern of custodial staff to be given a repressive role or of losing control; concern of health care professionals about increased workload with additional duties and having to deal with an unfamiliar category of patients; concern that prisoners could receive less qualitative care in public health services than the public.³³

Some countries have considered or planned the transfer of the responsibility and management of prison health care services from the Ministry of Justice to the Ministry of Health/public health authorities but have so far failed to complete the process, mainly due to insufficient preparation by the public health authorities.

31. Public Health England. Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England.

Leaman J, Richards AA, Emslie L and O’Moore EJ: Improving health in prisons – from evidence to policy to implementation – experiences from the UK. *International Journal of Prisoner Health* 13; 139-147, 2017.

32. WHO/UNODC: Good governance for prison health in the 21st century. A policy brief on the organization of prison health. https://www.who.int/hiv/pub/prisons/prison_health/en/

33. Palumbo R, Annarumma C, Adinolfi P, The dance of change in penitentiary care: window dressing or a new penitentiary care recipe? *Studi Organizzativi* 2:17-43, 2018 DOI 10.3280/SO2017-0020021.

Dubois C, Linchet S, Mahieu C, Reynaert J-F, Seron P. Organization models of health care services in prisons in four countries. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2017. KCE Reports 293. D/2017/10.273/69.

In spite of different organisational and management structures of health care for prisoners, full consent is expressed in the above-quoted Recommendations of the Committee of Ministers of the Council of Europe, the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)³⁴ and the WHO declarations that health care for imprisoned and detained persons is a whole state responsibility and should be as closely as possible aligned to, integrated into, and compatible with national health policies.

34. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

Inter-sectoral collaboration

Given that providing health care for prisoners is a whole state responsibility and that health care inevitably involves many actors in different sectors, there is a need for leadership and responsibility from the highest levels of government as well as mechanisms to ensure collaboration between both, at national level (in some States responsibility may be devolved to regional level such as Länder, Cantons, devolved administrations) and at local levels. Allocation of resources and transfer of resources when services are transferred from one administration to another is often a contentious issue, so the finance ministry should be part of the inter-sectoral mechanism of collaboration.

One mechanism to ensure optimal use of available resources, to determine additional needs and to ensure effective collaboration would be an inter-ministerial steering committee under the prime minister's office.

Whether responsibility for providing health care is given to the Ministry of Health or remains under the prison administration, both authorities have to assume responsibilities. Other sectors are also involved such as the police, often tasked with transferring prisoners to hospitals and ensuring security during consultations.

There is a clear advantage in terms of police resources in providing specialist consultations within prisons and thus decreasing the need for police escorts to hospitals. Setting up such consultations however, requires resources from another sector to employ specialists and equip consultation rooms, for example to allow ophthalmological, ear-nose-throat or gynaecological examinations. Similarly the advantages of having radiological and

ultrasound (echography) equipment within a prison health service are obvious, but require investment and trained staff.

At a local level, there should also be channels of communication and mechanisms to resolve disputes. The needs of prisoners must be recognised by hospital managements and the authority of doctors working within prisons respected. The duty to care should be extended to all specialists, to prevent obstacles and resistances leading to delays in surgical operations and other specialist treatments. Prisoners should have real access to the whole range of health care available to the general public, including the most sophisticated and costly: modern techniques of imagery such as computed tomography scans and magnetic resonance imaging, chemotherapy and radiotherapy for cancer, cardiac surgery, neurosurgery and transplantation.

At a practical level, there should be the necessary infrastructure to allow these investigations and treatment to be carried out while respecting the prisoner's intimacy and privacy. This must necessarily involve advance planning and investment involving the hospital authorities, the prison authorities and the police. Trying to find solutions when a particular need arises will almost always lead to suboptimal solutions.

However, if responsibilities for health care of prisoners are distributed, there will be a need for advance planning and inter-sectoral collaboration.

Health care for imprisoned persons: a whole state responsibility

When a state deprives individuals of their liberty, it takes on a special responsibility to look after their health. Imprisoned persons have no alternative but to rely on the authorities to protect and promote their health. To safeguard their right to health, international law subordinates to the state a legally enforceable duty of care in terms of both, the conditions under which it detains them and the individual treatment that may be necessary.³⁵ The obligation of governments to provide proper health care for the imprisoned persons has implications not only for the prisoners and the prison administrations but also for the Public Health of the whole state.³⁶ The need for close cooperation and integration of prison health care with public health structures is therefore a consequence of these implications.

In terms of governance and management of prison health care, it is the obligation of the state to ensure responsibly proper health care for the imprisoned persons and also a direct accountability of the government and parliament.

On the basis of this concept, as an example of good policy, several member States have subordinated medical departments directly to the relevant ministry rather than to prison administrations. Such structures also prevent that financial constraints or lack of resources of prisons or prison administrations are used as a justification for deficient health care for imprisoned individuals. One of the basic principles of the European Prison Rules stipulates that "Prison conditions that infringe prisoners' human rights are not justified by

35. United Nations: International Covenant on Economic, Social and Cultural Rights Art.12 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>; UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html>

36. WHO Moscow Declaration on Prison Health as Part of Public Health. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health>

lack of resources.”³⁷ The CPT emphasises also that “it is aware that in periods of economic difficulties – such as those encountered today in many countries visited by the CPT – sacrifices have to be made, including in prison establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment.”³⁸

37. European Prison Rules 2006, Council of Europe Rule 2. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d8d25

38. Council of Europe. CPT standards: Substantive sections of the CPT’s General Reports, Extract from the 3rd General Report 1993, <http://hudoc.cpt.coe.int/eng?i=p-standards-inf-1993-12-part-en-1>

Prison: a pathogenic environment and an opportunity for improving health

Prisons are a paradigm for what the sociologists Goffmann and Foucault called “total institutions”,³⁹ i.e. closed settings cut off from the outside society, with hierarchic structures regarding all aspects of life in one and the same spot, repressive and bureaucratic regime, strict discipline and constant surveillance provoking violent subcultures and prisoners having little if any individual responsibility and deprived from their social ties, resources, privacy, stimuli, choices and autonomy. These characteristics are completely contrary to what the WHO regards as an environment promoting health.⁴⁰ They are particularly detracting from the psycho-social well-being and deteriorate the existing psycho-social and mental disorders of persons living in such environments. This is all the more a matter of concern as, according to internationally collected data,⁴¹ up to 70% of imprisoned persons suffer from a mental disorder. The leading cause of death in prisons is suicide, about half of all prison deaths.⁴²

39. Goffman, Erving (1961). *Asylums: essays on the social situation of mental patients and other inmates*. Anchor Books

Foucault Michel (1975), *Surveiller et punir, naissance de la prison*, Paris, Gallimard

40. WHO The Ottawa Charter for Health Promotion. <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

41. Fazel S, Danesh J. Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *Lancet* 2002; 359: 545–50.

42. Fazel S, Baillargeon J. The health of prisoners. *Lancet* 2011; 377: 956–65

In addition to mental health problems, violence, drug dependency and infectious diseases, tuberculosis, hepatitis B and C virus (HBV, HCV) diseases and HIV disease are also dominant health problems in detention and prison settings. Worldwide, there is a consistently higher prevalence of HIV, HCV, HBV, tuberculosis and tuberculosis/HIV co-infection among prisoners than in the community, especially among imprisoned persons who inject drugs. This is due to the disproportionately higher incarceration rate of persons from underprivileged people in the society and the mass incarceration of persons who inject drugs.⁴³

The limited living space in prison, prisoners' continued risk behaviour and the insufficient prevention or harm reduction measures increase transmission in prison, causing epidemic outbreaks of the infectious diseases afflicting prisoners but also prison staff, relatives and the community after release from prison. According to a recent comprehensive global survey and analysis of prevention interventions, the most effective way of controlling these infections in prison is to reduce incarceration for persons who inject drugs and to use more non-custodial sanctions.⁴⁴

However, imprisonment can also offer an opportunity for improving health care for individuals, particularly those who have been out of the reach of community health care services before imprisonment. For some of them, the medical examination on admission to prison may offer the first opportunity for a comprehensive medical assessment, which include detection, diagnosis and treatment of mental and/or physical health disorders. For individuals who have had a chaotic life style, particularly drug dependent patients, the enforced controlled and structured daily life in detention gives them for the first time the possibility to benefit from health education, health promotion, preventive measures (such as vaccinations and training) and application of harm reduction techniques.

In addition to opportunities for individual health care, health promotion, as part of a prison policy, upholds the health of all persons living and working in prisons, through available resources and abilities⁴⁵ and reduces health risks in the prison environment. Acknowledging the important role of the prison

43. Dolan K, Wirtz AL, Moazen B et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*(2016) 388:1089-1102

44. See footnote 43.

45. WHO Europe: Prisons and Health, 2014. Promoting health in prisons: a settings approach p. 180-184. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health>
WHO The Ottawa Charter for Health Promotion. <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

health in relation to public health and the implementation of a health promotion policy needs the support of the public health authorities. Health promotion in prison comprises not only health education (preferably through peer education techniques), disease prevention and harm reduction but also mental health promotion. Examples of concrete mental health promotion policies include: reduction of stress by providing personal support, increased abilities to cope with imprisonment and prevention of suicide, guaranteeing safety and a clean and hygienic environment, creating an atmosphere of decency and respect, appreciation for the work, improvement of knowledge and competences; support for creativity at work, education and leisure time, increased contacts with the outside world, individual privacy and availability of a variety of choices.

More specifically the benefits from such health promotion policies in prison are the following:

- ▶ for the **imprisoned persons**: increased emotional and physical well-being, coping abilities, confidence and social skills, ability to use time properly and plan realistically for the future; social inclusion and improved rehabilitation prospects; reduction of already experienced mental disorders or the likelihood to develop physical or mental disorders;
- ▶ for **the staff**: higher morale and satisfaction at work, less tension and stress, improved mental and physical health;
- ▶ for **the prison**: improved security through better staff–prisoner relations, safer environment with reduced tensions and assaults, easier recruitment and retention of staff, lower sickness absence/ill-health retirement rates, greater efficiency and cost-effectiveness;
- ▶ for **the community**: higher likelihood of successful rehabilitation of the released prisoners in the community, reduced spread of infectious diseases, less mental disorders among released prisoners and increased safety.

Co-operation and integration of prison health care services with public health structures

The Commentary to the European Prison Rules highlights the following about Rule 40, regarding close relation, integration and compatibility with national health policies:

“The most effective way of implementing Rule 40 is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries. If this is not the case, then there should be the closest possible links between the prison health care providers and health service providers outside the prison. This will not only allow for a continuity of treatment but will also enable prisoners and staff to benefit wider from developments in treatments, in professional standards and in training.”⁴⁶

There are many reasons why high quality health care services in prison are reliant on close cooperation and integration with health authorities and health services in the community.

As emphasised in the above-quoted ethical principles of prison health care, it is virtually impossible to achieve and keep equivalence of high quality health care without close co-operation with public health structures.⁴⁷ The principles of professional independence and professional competence of health care staff in prison likewise rely much on alignment to community health policies.

46. Commentary to Recommendation R(2006)2 the European Prison Rules of the Committee of Ministers to member States on the European Prison Rules. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680795966

47. WHO/UNODC: Good governance for prison health in the 21st century. A policy brief on the organization of prison health. https://www.who.int/hiv/pub/prisons/prison_health/en/

Prison administrations rarely, if ever, have the expertise and tools for professional inspection and control of hygiene, sanitation, food, water and safe disposal of general and medical waste. In most prison jurisdictions the head physician of the prison is pledged to these inspections but often lacking the required training, expertise and equipment. In addition, professional supervision of these crucial matters from outside competent bodies, such as the Ministry of Health or other public health authorities will result in more objective and independent judgement and proposals for improvement.

Furthermore, prison administrations rarely, if ever, have the expertise to adequately judge complaints by prisoners concerning health care. These complaints should be brought to the attention of independent health professionals. Health care staff in prison should be subject to the same disciplinary procedures as health care staff in the community. Prisoners should be entitled to make complaints about health care directly to the disciplinary body, without passing through the prison management and should be heard by the disciplinary body.

It is a matter of concern that in several member States the premises, equipment and professional qualification of health care services in prison are not part of the licensing and accreditation procedures, as required for health care services in the community. This relates also to the requirement and proof of CME of health care professionals working in prisons. A major weakness of prison health care in member States, as identified in the SWOT (strengths, weaknesses, opportunities, threats) analysis of the above-mentioned Council of Europe questionnaire survey, was the lack of structured training and CME of prison health care professionals, a flaw that needs and can be remedied with support of and collaboration with public health training and CME institutions.

Licensing, accreditation and proof of CME of prison health care services should be managed by the public health authorities through their health care expertise and administrative structures.

In many countries, a considerable number of complaints by the imprisoned persons are related to health care. Public health authorities have the required medical competence and objectivity to deal with these complaints. Co-operation is therefore needed also in this regard.

A thorough national assessment and survey of the epidemiological data cannot disregard the epidemiological data obtained from the imprisoned persons. Particularly infectious diseases, such as HIV disease, blood borne

hepatitis and tuberculosis as well as drug dependency and mental disorders have a considerably higher prevalence in the incarcerated population than in the community. In addition to the legally required reporting of notifiable diseases, sharing anonymous epidemiological data on prisoners with the national health authorities is a prerequisite for obtaining a complete overview of the epidemiological situation in a country. This facilitates the planning for both, acute epidemiological emergencies and appropriate long-term public health initiatives which include imprisoned persons in the same way as the persons in the community. The implementation of harm reduction measures in prison in close co-operation with public health structures in the community to prevent the spread of transmissible diseases is one important example of such common efforts.⁴⁸

On the level of individual care, the imprisoned persons go through a particularly hazardous phase regarding continuity of care after release from prison. In order to reduce individual health risks and threats to public health, continuity of care needs to be carefully prepared in close collaboration with community health care services. These risks comprise the transmission of infectious diseases or development of treatment resistant disease if treatment and/or harm reduction measures are discontinued and the risk of post-release mortality, in particular in drug dependent persons.

Close co-operation with civil health care structures is also needed when imprisoned persons are in need of hospital care that cannot be provided within the prison system. The planning and provision of sufficient beds, based on a careful needs assessment in co-operation with civil hospital facilities allow for emergency treatment, selective hospital treatment and their optimal and transparent use.

Medical documentation of prison health care services should be closely aligned to medical documentation in the community, i.e. there should be used the same medical record forms, either in hard copy or in electronic medical records (EMR) with obligatory International Disease Classification (ICD) in accordance with the WHO coding system.⁴⁹ This facilitates medical information flow on transfers from prison to prison and/or to civil hospitals and upon release to health care professionals in the community. The documentation of pharmaceuticals management and administration of medication

48. UNODC, WHO, UNAIDS, ILO: Policy brief. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. http://apps.who.int/classifications/icd10/browse/2010/enwww.who.int/hiv/pub/prisons/interventions_package/en/

49. International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2016. <http://apps.who.int/classifications/icd10/browse/2016/en>

in prison should also use the same documentation systems as in the community health care facilities. For establishing EMR in prison, including medication management, compatible with those in the community health care facilities, close co-operation and integration with public health structures is needed.

Staffing and recruitment of health care staff

In the above-mentioned Council of Europe questionnaire survey SWOT analysis, lack of sufficient health care professionals in prison and lack of structured training and continuous professional development, were the dominant identified weaknesses. In some member States a general shortage of health care professionals in the community added to other reasons quoted regarding the shortage of prison health care staff, such as: challenging working conditions and patients, low professional recognition and social reputation and insufficient remuneration. In comparison to the healthcare staff working in public health institutions, salaries in the prison service were reported lower in 11 countries, higher in 7 countries and equal in the rest of them.

Shortage of health care staff is no justification for involving imprisoned persons in health care tasks that require specialized training, even if they have medical qualifications, or as medical orderlies or in distributing medication.

The survey showed also that the employment patterns for health care professionals working in prison vary considerably among member States: uniformed prison staff in military ranks, civil servants, contract-based employees, full-time and part-time employees and health care professionals working exclusively in prison or in both, prison and community. In the majority of member States there are mixed types of employment.

Uniformed health care professionals and civil servants report on higher social reputation, better social benefits and remuneration, however, particularly uniformed health care professionals bound in military hierarchies, face considerable challenges in keeping professional independence and medical confidentiality while working with non-medical superiors and when trying to obtain the trust from their patients. Health professionals who exclusively work in prison with a full-time employment may guarantee continuity of medical care but are less likely to retain their sense of equivalence of health care with the community and the professional independence. They may also lack the intellectual stimulation and co-operation with colleagues in the community health services.

The ratio number of full-time health care staff to the number of prisoners in member States, as reported in the survey, ranged from 1/15 to 1/140, median 1/43. The latter figure matches also with the SPACE report 2015⁵⁰ on 36 countries that provided data on full time employment of healthcare staff: 1/41 (range 1/5 to 1/667). There is no set standard for this ratio for several reasons: size, structures and tasks of penal institutions vary considerably – e.g. pre-trial detention centres with a much higher prisoner turnover and frequency of time spent on medical examinations on admission will need a greater availability of primary health care staff than in facilities for sentenced persons –; the level of professional training and skills of doctors and nurses or feldshers differ considerably from country to country – e.g. in some countries general practitioners have a sound knowledge on mental health care, whereas in some other countries they lack such training or nurses or feldshers are qualified in taking over far-ranging medical responsibilities that might be unacceptable in other countries. However, there are set minimum requirements outlined in international recommendations. The European Prison Rules and their Commentary⁵¹ emphasise:

All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose. Every prison shall have the services of at least one qualified general medical practitioner. Arrangements shall be made to ensure at all times that a qualified medical practitioner is available without delay in cases of urgency. Where prisons do not have a full-time medical practitioner, a

50. Council of Europe Annual Penal Statistics, <http://wp.unil.ch/space>

51. European Prison Rules 2006, Council of Europe Rule 2. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d8d25

Commentary to Recommendation R(2006)2 the European Prison Rules of the Committee of Ministers to member States on the European Prison Rules. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680795966

part-time medical practitioner shall visit regularly. The services of qualified dentists and opticians shall be available to every prisoner. In large prisons a sufficient number of doctors should be appointed on a full-time basis. In any event, a doctor should always be available to deal with urgent health matters. The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention.

The Nelson Mandela Rules⁵² stipulate:

The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner. All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care. The physician or, where applicable, other qualified health-care professionals shall have daily access to all sick prisoners, all prisoners who complain of physical or mental health issues or injury and any prisoner to whom their attention is specially directed.

The required number of health care staff for each prison is best determined by an on-going needs assessment, performed by health care professionals with respective documentation (best facilitated by electronic health care data management) of the work load, consultation frequencies and duration and the patients' needs for both, primary and secondary health care. For instance, for primary health care professionals it needs to be taken into account the time-consuming tasks during the medical examination on admission, such as: obtaining and recording the patient's medical history, conducting a thorough physical examination, screening on mental disorders, suicidality, drug use, withdrawal symptoms, contagious diseases, mental or physical disabilities, signs/records of violence and ill-treatment as well as providing information about the organisation of the medical services in the prison, the medical team's professional independence and confidentiality and their limitations, prisoners' rights and responsibilities, the risk of the spread of transmissible diseases and the harm reduction measures available in the prison.

52. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

Secondary health care out-patient services by specialists are most efficiently conducted on a policlinic-based model, i.e. contracted specialists visiting and consulting patients in the medical unit of the prison regularly and/or upon need.

Many member States face considerable difficulties in recruiting health care professionals to work in prison, resulting in a number of vacant positions. In order to overcome this situation, several member States resort to various incentives for recruiting health care professionals, such as: increasing salaries, comparable with those in the community, providing a danger bonus, establishing collaboration with medical schools and offering internships, paying training costs for pre-engagement to work in prison for a set number of years, early retirement or social benefits.

Given that prison health is an important part of public health,⁵³ public health authorities should acknowledge their responsibility to support prison administrations in solving the problem of recruitment of health care professionals caring for imprisoned persons.

Common efforts are also needed to explain to the public and decision makers that providing health care in prison is an important service to the public health of the community. The specialist knowledge of health care professionals cope with all the particular forms of prison pathology and the required skills and experience to manage them under the conditions imposed by the prison environment, are widely underestimated, by both, society and medical colleagues. The CPT suggests that the specific features of the provision of health care in a prison environment may justify the introduction of a recognised professional speciality for both, doctors and nurses, on the basis of postgraduate training and regular in-service training.⁵⁴ A wider recognition of these professional demands may raise the professional and social reputation of the health care staff caring for the imprisoned patients and may encourage recruitment.

53. WHO Moscow Declaration on Prison Health as Part of Public Health. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health>

54. Council of Europe. CPT standards: Substantive sections of the CPT's General Reports, Extract from the 3rd General Report 1993, <http://hudoc.cpt.coe.int/eng?i=p-standards-inf-1993-12-part-en-1>

Primary health care

According to the WHO, primary health care (PHC) is about caring for people, rather than treating specific diseases or conditions. PHC is usually the first point of contact with the health care system. This includes a spectrum of services from prevention to screening, identification and management of acute and chronic health conditions and palliative care. PHC in prison is no different; it is only a special setting for primary health care. The primary health care service should know the patients' needs on admission, particularly related to mental health, addiction problems and infections, most common in prison. It should care for them during their imprisonment and help them to prepare for release.⁵⁵ For a considerable number of imprisoned persons who have been out of the reach of community health care services before their imprisonment due to adverse social conditions or a chaotic life style, PHC services in prison may constitute the first opportunity of a comprehensive medical assessment with detection, diagnosis and treatment of mental and/or physical health disorders.

*In addition to screening for mental and physical health conditions, the medical examination on admission needs to screen **also** for signs of injuries and ill-treatment that might have occurred before admission to prison. **It is important** to record allegations, observe and document the lesions, draw conclusions about the compatibility of allegations and the observed lesions and to report the cases in accordance with CPT recommendations⁵⁶ and the Istanbul Protocol.⁵⁷ The same needs to be pursued after each event of violence during imprisonment.*

55. WHO Europe: Prisons and Health, 2014. Promoting health in prisons: a settings approach p. 180-184. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health>

56. CPT: Documenting and reporting medical evidence of ill-treatment. Extract from the 23rd General Report of the CPT, published in 2013. CPT/Inf(2013)29-part.

57. Istanbul Protocol OHCHR <https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

The PHC team should consist of an inter-professional team with a sound knowledge and updated training in general health care or family medicine, mental health care and addiction medicine and should also include a qualified dentist or stomatologist and a pharmacist for professional management of medication. In the prisons where women, mother-child or juveniles are detained, the PHC team should have sufficient training and skills to meet their special needs, thus, to provide gynaecological care, obstetric care and care by a paediatrician. The right to contraceptive medication and voluntary termination of pregnancy (IVG) should be the same as for women in the community. When women are allowed to have their young children with them, there should be regular paediatric care available, where the paediatrician sees the child in the presence of the mother, under conditions of confidentiality.

With the exception of medical emergencies, the primary health care in prison should be practiced in appropriately equipped and designated consultation and intervention rooms in a medical unit in order to ensure medical privacy and confidentiality, with locked storage for confidential medical files. For dental interventions, an adequately equipped dentist surgery room is needed. Additional rooms should be available for consultations by contracted specialists visiting the prison and for meetings of the team of health care professionals. Primary health care may also include the temporary nursery of patients in an infirmary or day-clinic in the prison.

Primary health care services in prison, the same as in the community, can play an important role as gate keepers for secondary health care, reducing inappropriate use of expensive hospital and other secondary health care facilities. This may include effective care in well-equipped prison infirmaries and/or day clinics not only for nursing and treatment of prisoners with minor infections or other minor acute disorders but also for many chronic disorders not needing hospital care, under the supervision of primary health care staff and/or guidance of specialists. Efficient communication and co-operation should be established with hospital facilities in the community to promptly transfer patients in need of hospital care and/or other secondary or tertiary health care services not available in prison. Like all other medical units, prison infirmaries need to be licensed for their purpose by the health authorities of the country.

The primary health care team in prison has also the responsibility to ensure optimal health care management in cases of medical emergencies. This comprises: availability of updated training of all staff in First Aid, organisation of emergency medical treatment on the spot, support for the PHC team from outside emergency services that are not available in prison and a prompt availability of professional ambulance transportation for emergency hospital care.

Secondary health care and hospital care

Secondary health care comprises all health care that needs specialist medical expertise, either in an out-patient setting or in a hospital. The care in highly specialized hospital reference centres is regarded as tertiary health care. A large part of secondary health care can be provided in outpatient settings with the involvement of specialists, thus sparing expensive stationary hospital treatment.

Out-patient secondary health care for prisoners can be provided by specialists employed in prisons, contracted specialists coming into the prison (polyclinic structure) or by escorting prisoners to specialists outside prisons e.g. to outpatient departments of community health care facilities. The polyclinic model, i.e. employed or contracted specialists practising in equipped medical rooms in prisons, on scheduled visits or upon call, is preferred in terms of both, security and cost effectiveness. This is particularly important in the long run, even if specialized non-portable diagnostic equipment, such as ultrasound and echocardiography equipment need to be procured upon carefully calculated needs assessment in cooperation with the contracted specialists. A good part of conservative (i.e. non-operative) treatments that result from specialist diagnostic services can safely be applied as outpatient treatment in prison or in prison infirmaries/day clinics under the guidance of specialists, as outlined above. Furthermore, pre-operative and post-operative care that does not need hospital care can be conducted under specialist surveillance and in co-operation with the surgical centre in prison infirmaries thus, reducing the time of stay of these patients in expensive hospitals.

Hospital care for prisoners can in principal be provided in prison hospitals or in community hospitals. The above-mentioned Council of Europe survey showed that only 29 out of 45 prison systems had prison hospitals. The capacity ratios of available prison hospital beds/number of prisoners, the number of hospitalised imprisoned persons and the duration of stays in prison hospitals and in civil hospitals was as shown in Table 1.

Table 1: Prison systems with and without prison hospitals

Prison systems with prison hospitals: 29/45		
	median	range
capacity ratio beds/prisoners:	1/54	1/7 – 1/3381
prisoners hospitalized/year:	11%	1% - 39%
duration of stay, days:	30	1 - 424
hospitalized in civil facilities	7%	1 – 20%
Prison systems without prison hospitals: 16/45		
Hospitalized in civil facilities/year:	7%	6 – 16%
Duration of stays, days:	4	2 - 22

When looking into the advantages of prison hospitals compared to having all hospital care arranged in community facilities, the most common argument in favour of prison hospitals is the already established safety and security.

In terms of medical treatment and medical-ethical aspects, there is little, if any advantages of prison hospitals compared to hospital services provided to prisoners in the community hospital facilities. As far as major surgery is concerned, there is scientific evidence that the low frequency of major surgical interventions in prison hospitals in comparison to large civil hospitals is disadvantageous for patients because of a clear relationship between higher surgical volume and lower postoperative mortality in larger hospitals. In addition, the professional expertise and equipment needed in order to guarantee the same level of surgical safety and quality as in community hospitals are rarely, if ever, affordable in the prison system, e.g. if post-operative intensive care unit (ICU) becomes necessary.⁵⁸ This is also the case for non-surgical intensive medical interventions in need of highly specialised expertise and equipment, such as in acute coronary heart disease, acute vascular brain

58. Urbach DR. Pledging to eliminate low-volume surgery. *N Engl J Med* 2015;373:1388-1390

disease etc. Disregarding these arguments can lead to violation of the ethical principle of equivalence of care.

Establishing separated secured wards for prison patients in the clinical service of the community hospitals with separate entrance and fenced from civil patients and guarded by a small team of security officers, allows for equivalent clinical care and avoids frictions with the community part of the hospital. The use of common human resources, premises and equipment for both civil and prisoner patients at a large community hospital facility, be it private or state owned, is more cost effective for the state rather than having separate prison hospitals for a comparatively smaller number of patients in prison in real need of hospital care.

When planning the needed number of beds for hospital care for prisoners it should be assured that each emergency case can be admitted immediately, whereas for planned hospital interventions, such as selective surgical interventions, a transparent waiting list should be established. The electronic waiting list for hospital admissions, arranged by the Georgian prison system, may serve as an example of good practice in this regard as it prevents undue preferences of certain prisoners. Likewise, the duration of hospital stays of patients' needs to be decided and documented exclusively on traceable medical grounds in order to maintain the needed capacity for emergency cases and to avoid undue hospital stays.

Providing mental health care to prisoners

Providing mental health care to persons in prison is a challenge. The often stated aim is to provide care equivalent to that available in the community and community hospitals. This equivalence is rarely achieved.

Recommendation R(98)7 of the Committee of Ministers of the Council of Europe requires *“The prison administration and the ministry responsible for mental health (to) co-operate in organising psychiatric services for prisoners”*. This recommendation is rarely followed.

“Prisons are bad for mental health” is the blunt conclusion of a joint WHO and ICRC fact sheet on mental health care for prisoners.

Indeed as shown in the section on the case law of the ECtHR, the prison environment is nearly always toxic for persons with mental health disorders. Many factors are responsible including:

- ▶ the loss of social support mechanisms,
- ▶ overcrowding,
- ▶ the frequent use of seclusion for prisoners with mental health problems displaying disruptive behaviour, threats of suicide or self-harm,
- ▶ conflictual relations with other prisoners (such prisoners are often on the bottom rung of the prison hierarchy),
- ▶ endemic substance abuse,
- ▶ stress related to criminal proceedings,
- ▶ exposure to stigma and discrimination.

As a result self-harm, suicide, inter-prisoner violence, behaviour disorders and violent conflicts with prison staff are common among prisoners with mental health problems.

One psychiatrist working in prisons observed: "There are worrying reports of prisoners, especially those with serious mental illness, being bullied, exploited and isolated, with little chance of them being supported or protected and of a resulting increase in self-harming and assault."

Above all the negative effect of the prison environment on mental health gives rise to a high degree of suffering, related to worsening of psychiatric symptoms, and to failures in rehabilitation and re-integration at the time of release.

The prevalence of mental disorders is far higher in prisons than in the community in general. Experts have long warned of high levels of mental illness in the prison population and the situation appears to be worsening with one estimate suggesting that about a quarter of the total prison population have bipolar disorder, depression or personality disorders. Other studies show that around a quarter of women and 15% of men in prison reported psychotic episodes. The rate among the general public is about 4%.

Some observers have claimed that prisons are sometimes used as dumping grounds for people with mental disorders and that the aim should be to divert people with mental disorders towards the mental health system. This aim has proved unrealistic. Many persons suffering from mental disorders entering prison have had previous contacts with outside mental health services but have not continued their treatment due to adverse social circumstances. Another factor increasing the problem inside prisons is that psychiatric services in the community are frequently overstretched with a chronic shortage of beds in hospitals. It can be said that prisons are often victims of failures in community health care. Community mental health services often fail when mental health problems are combined with social problems: poverty, homelessness, illegal foreigners, unemployment. Such people often end up in prison. Many prisoners with mental health problems have not received adequate care in the community and the profile of mental health problems seen in prison is particularly challenging.

As a result, both prison administrations and prison health services have to live with the reality that a significant proportion of the prison population suffer from mental disorders. What is more the psychiatric morbidity is often of a kind particularly difficult to manage and treat: borderline personality and anti-social personality disorders, bipolar disorders and a range of disorders complicated by substance abuse, which may continue inside prison.

Therefore, in every prison there should be access to appropriate mental health treatment and care as an integral part of general health services available to all prisoners. Practically this means that primary care physicians have the necessary skills to detect mental disorders. They should be backed up by the regular presence of psychiatrists and other mental health professionals and the availability of psychosocial support and rationally prescribed psychotropic medication. A dedicated team is needed to help substance users to deal with their problems with access to maintenance therapy, when this is available in the community.

The needs of prisoners should be included in national mental health policies and plans.

There is an obvious need to diagnose mental health problems on entry to prison, particularly when there is a risk of suicide. Persons with untreated psychotic disorders may be placed in seclusion where the risk of self-harm or suicide is high. Substance abuse leading to withdrawal symptoms needing treatment is common. Vulnerable prisoners may develop reactive depression and anxiety.

There is also a need for hotline between prison medical services and community mental health services to identify patients already receiving psychotropic medication prior to imprisonment, patients on maintenance therapy for substance abuse and persons out of contact with community mental health services but known to have mental health problems.

During the prison stay ambulatory mental health care should be provided by a multidisciplinary team of psychiatrists, mental health nurses, psychologists and psychotherapists. The same range of psychotropic medication should be available as in the community, without cost to the prisoner.

Special programmes for prisoners with personality disorders require active involvement of both, mental health professionals and prison staff and have been shown to reduce self-harm and anti-social behaviour in prison.

Some prisoners will present acute states of their mental disorder (severe depression, decompensated psychosis, acute suicidal risk) which cannot be treated in prison. It should therefore be possible to rapidly transfer such prisoners to a psychiatric hospital, if necessary on the same day as the need arises. Dealing with such situations by placement in seclusion within the prison, is unacceptable.

However psychiatric hospitalisation is often seen as creating a risk of escape. Therefore the judicial or administrative authorities may step in to refuse the transfer to hospital. Another adverse consequence of the perceived risk of escape is that the prisoner is immediately placed in seclusion, and sometimes under physical restraint on arrival at the hospital and kept under such conditions throughout the hospital stay, without access to a full range of therapeutic activities.

The CPT has repeatedly drawn attention to this unacceptable state of affairs. The problem of psychiatric hospitalisation of prisoners under conditions corresponding to “equivalence of care” remains unsolved in most members of the Council of Europe. Two specific initiatives are therefore worthy of mention:

- ▶ In France “*Specially Adapted Hospital Units*” (UHSA) have been opened as an integral part of public mental hospitals. Psychiatrists, nurses, psychologists, therapists are recruited and paid by public psychiatric services. The standards of care are the same as in other hospital units. Perimeter security, entry/exit and visits are under the authority of the prison service. This provides an excellent example of successful collaboration between health and prison administrations, involving substantial capital investment and running costs and leading to a vast improvement in mental health care of prisoners with serious mental disorders.
- ▶ In the Netherlands, the prison authorities have taken the initiative to create four “*Penitentiary Psychiatric Centres*” (PPC) providing 620 places for psychiatric care within prisons. The frontline carers are prison officers with two-year training in taking care of psychiatric patients. Psychiatrists are employed by the Netherlands Institute of Forensic Psychiatry.

The CPT has visited both UHSA and PPC recently and gave a generally favourable assessment to both very different models of care.

Key questions to prison health care organisation and management – a checklist

Organisation, legal and administrative framework

1. Is health care in prison under the direct responsibility of a ministry (rather than under the sole responsibility of the prison governor)?
2. Do national health laws (implicitly or explicitly) include health care in prison?
3. Do legal regulations for health care in prison fully comply with national health laws?
4. Is there an inter-ministerial committee for inter-sectoral collaboration of prison health care management?
5. Is the health care budget separated from the general prison budget?
6. Are there written National Standards for prison health care and/or SOPs for selected critical scenarios in prison health care?

Premises

7. Is there a structured regular supervision of healthy living conditions for prisoners, i.e. space, hygiene, sanitation, food, water, heating, lightning and safe disposal of waste from outside competent bodies such as the Ministry of Health or other Public Health authorities?

8. Are premises, equipment and professional qualification of health care services in prison submitted to the same licensing and accreditation procedures required for health care services in the community?

9. Do premises for primary health care fulfil the required demands of space, barrier-free accessibility, privacy and confidentiality?

Health care staff

10. Are all positions of the health care staffing plans in prisons occupied?

11. Are salaries for prison health care professionals at the same or higher than salaries for comparable health care professionals in the community?

12. Do health care professionals working in prison undergo the same CME-PHC as their colleagues working in the community?

13. Are primary health care professionals appropriately staffed and trained for thorough conduct of medical examination upon admission?

14. Does primary health care staff in prison have the full competence of a general practitioner or family doctor or nurse, a sound knowledge of medical ethics in prison and of all those health disorders that are especially prevailing in prison such as mental health disorders, drug dependency, transmissible diseases and the professional screening, documentation and reporting of violence?

15. Does health care staff working in prisons for female and juvenile prisoners have the appropriate qualifications for meeting the needs of the prisoner?

16. Are health care professionals integrated in uniformed prison staff informed that they should not wear uniforms when providing health care to prisoners?

Primary Health Care

17. Is medical examination/consultation upon admission or upon the request of a prisoner conducted without delay and never later than 24 hours after admission or after request?

18. Is application for medical consultation guaranteed confidentially and without pre-selection by non-medical staff?

19. Are health care services available for free or do prisoners have to pay (officially or unofficially) out of their pocket?

20. Is there ready access to appropriate mental health care as an integral part of general health services available to all prisoners?

21. Is a qualified dentist with adequate dental care facilities available for free in each prison?

22. Is the health care team immediately informed about persons brought to solitary confinement for disciplinary reasons?

23. Is seamless continuity of care of imprisoned person upon release provided by cooperation with support structures in the community?

Secondary and hospital health care

24. Is access to additional specialized medical services - on out-patient basis and/or hospital care – without undue delay guaranteed whenever needed?

25. Is a psychiatrist/clinical psychologist available in each prison and is psychiatric inpatient care in an appropriate mental health care facility available without delay if needed?

26. Is gynaecological, obstetric and paediatric care available for imprisoned women and mothers with children on a regular basis?

27. Is there a ready access to civil health facilities without undue delay whenever prison health facilities cannot provide the required health services?

28. Is all major surgery and all non-surgical intensive medical interventions of prisoners in need of highly specialised expertise and/or equipment performed in civil health care facilities?

29. Is there a transparent waiting list for selective medical interventions in hospitals preventing undue preferences of prisoners and allowing for immediate interventions in medically urgent cases?

Prevention and health promotion

30. Are imprisoned persons included in all national health initiatives?

31. Are defined strategies for the prevention of transmissible diseases such as TB, HIV/AIDS, Hepatitis B/C including harm reduction measures in place in all prisons and are they in accordance with the UNODC/WHO/ILO/UNAIDS recommendations⁴⁶?

32. Are these strategies in compliance with and/or integrated into the national strategies for prevention and harm reduction measures of these transmissible diseases?

33. Is there a defined inter-professional health promotion - including mental health promotion -programme or initiative in each prison?

Health care documentation

34. Do medical documentation and medical records/electronic medical records in prison fulfil the same requirements as medical documentation in the community and are they compatible with each other?

35. Are medical files kept confidentially and locked with access only to the health care staff and the patient with the only exception of explicit permission by the patient or an order by a court to disclose defined patient-related health care data?

36. Is ICD coded documentation used by all health care professionals working in prison?

37. Is there a structured regular reporting of epidemiological data obtained in prison to Public Health authorities or to the Ministry of Health?

Medicines and health care equipment

38. Is an updated list of essential medicines in accordance with the WHO Model List of Essential Medicines⁵⁹ in use for procurement of medication for prisoners in primary health care?

39. Are all medications required for primary health care according to the updated list of essential medicines (WHO) available?

40. Is management, storing, and replacement of medications supervised and controlled at central and all peripheral levels by trained and certified pharmacists?

41. Is there an updated list of minimally required medical equipment for primary health care in place and is their repair/replacement guaranteed?

Health care ethics

42. Is the prison health care staff exclusively involved in the care, health and well-being of prisoners (and not being expected to serve also for medical interventions in the interest of third parties)?

43. Is custodial staff informed that during medical consultation/examination of prisoners, as a rule, they should stay outside of the consultation room and out of vision and earshot for respecting medical confidentiality?

59. WHO Model list of essential medicines. <http://www.who.int/medicines/publications/essentialmedicines/en/>

44. Is patient's consent and right to refuse respected in all medical interventions in prison including medical examination upon admission and persons on hunger strike?
45. Is coercive treatment of mentally incompetent patients exclusively performed in mental hospitals and only upon the explicit order of a court?
46. Are clinical decisions and medical interventions by health care professionals conducted in absolute unrestricted professional independence without undue influence by the prison administration or other third parties?
47. Are there legal and administrative arrangements in place that allow for terminally-ill prisoner patients to die in freedom and dignity?
48. Is every known case of victim of violence before and during imprisonment immediately brought to the attentions of the health care staff for examination/consultation and professional recording and reporting according to CPT recommendations and the Istanbul Protocol?
49. Are all events of physical restraints, injuries, violence and alleged ill-treatment, self-harm, suicide attempts and suicides, hunger strikes recorded in respective registry books?
50. Are segregation procedures for medical reasons in line with the procedures in the community?
51. Are complaints by prisoners related to health care brought to the attention of independent health professionals?
52. Is health care staff in prison subject to the same disciplinary procedures as health care staff in the community and can prisoners make a complaint directly to the disciplinary body and be heard by the disciplinary body?

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- ▶ World Medical Association (2008) Declaration of Seoul on Professional Autonomy and Clinical Independence. Retrieved from: <https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinical-independence/>
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Appendix 1: International documents on organisation and management of prison health care

Council of Europe:

- ▶ European Convention on Human Rights. Retrieved from https://www.echr.coe.int/Documents/Convention_ENG.pdf
- ▶ Recommendation R(2006)2 of the Committee of Ministers to member States on the European Prison Rules. Retrieved from: <https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae>
- ▶ Recommendation R(93)6 of the Committee of Ministers to member States concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison. Retrieved from: <https://rm.coe.int/16804d7777>
- ▶ CPT standards (1993) Substantive sections of the CPT's General Reports, Extract from the 3rd General Report. Retrieved from: <http://hudoc.cpt.coe.int/eng?i=p-standards-inf-1993-12-part-en-1>
- ▶ CoE/WHO (2014), Strasbourg Conclusions on Prisons and Health, 2014. Retrieved from: <https://rm.coe.int/strasbourgconclusions-on-prisons-and-health-final-draft-20-june-2014/168075f56c>

United Nations:

- ▶ Human Rights Office of the High Commissioner (1982) Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Retrieved from: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>
- ▶ Constitution of the World Health Organization, www.who.int/governance/eb/who_constitution_en.pdf

WHO/UNODC:

- ▶ WHO (2013) Good governance of prison health in the 21st century: a policy brief on the organization of prison health. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

Appendix 2: Further Reading

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- ▶ WHO Regional Office for Europe (2010) The Madrid Recommendation: Health protection in prisons as an essential part of public health. Copenhagen. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf?ua=1
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- ▶ WHO Regional Office for Europe (2007) Trencin statement on prisons and mental health. Copenhagen. Retrieved from: (http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf?ua=1)
- ▶ UNODC (2011) Bangkok Rules, Rules for the Treatment of Women Prisoners and Noncustodial Measures for Women Offenders. Retrieved from: http://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf
- ▶ WHO (2014) Prisons and Health. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

This publication aims at providing guidance to policy makers and officials of relevant institutions to ensure that the health policy in prisons is integrated into, and compatible with, national health policy. The Council of Europe publication “Prison Health Care and Medical Ethics”- a manual for health care workers and other prison staff with responsibility for prisoners’ well-being, can be referred to, as a complementary guide with practical information regarding provision of health care in prison. These Guidelines are a result of a multilateral meeting on organisation and management of prison health care, held in Strasbourg in October 2017, as part of the Council of Europe co-operation activities in the penitentiary field, implemented by the Criminal Law Co-operation Unit. The text is also available online at: <https://www.coe.int/en/web/criminal-law-coop>

www.coe.int

The Council of Europe is the continent’s leading human rights organisation. It comprises 47 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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